THE OFFICE OF THE

INSPECTOR GENERAL

DMHMRSAS

SNAPSHOT INSPECTION

NORTHERN VIRGINIA MENTAL HEALTH INSTITUTE

ANITA EVERETT, MD

INSPECTOR GENERAL

OIG Report # 35-01

EXECUTIVE SUMMARY

A Snapshot Inspection was conducted at the Northern Virginia Mental Health Institute in Falls Church during January 15 - 16, 2001. The purpose of this Snapshot Inspection was to conduct a review in four main areas. These areas included the general condition of the facility, staffing patterns and issues, the activity of the patients and a review of some of the performance improvement initiatives undertaken by the facility as outlined in their previously submitted plans of correction.

The facility was clean and well staffed. The opportunity was taken to review action taken as a result of previous OIG recommendations. We found that there was not a formalized

process for tracking the accomplishment of specific OIG recommendations. Most of the recommendations made by OIG had been addressed either directly or indirectly.

Over the last several years, this facility has had tremendous difficulty with morale and staff turnover which could have posed a risk to quality of care. Based on interviews with a variety of staff, this now is dramatically improved. It is the function of hospital administrative staff to promote an environment that facilitates the delivery of quality professional care. Suffering with and working with serious mental illness is difficult on its own, constant administrative disruptions in programs designed to render aid to these individuals complicates and impedes the recovery process for all concerned. There is evidence at this time at NVMHI that stability in management and leadership at this facility have had a very positive effect on staff. This greatly increases my confidence level in the current overall quality of care at NVMHI.

FACILITY:	Northern Virginia Mental Health Institute Falls Church, Virginia
DATE:	January 15 - 16, 2001
TYPE OF INSPECTION:	Unannounced Snapshot Inspection
REVIEWERS:	Cathy Hill, M.Ed. Laura Stewart, LCSW
REVIEW ACTIVITIES:	A tour of several treatment units was conducted, clinical records were reviewed, and interviews conducted with patients and staff.

AUDIT BACKGROUND INFORMATION

The purpose of this Snapshot Inspection was to conduct an inspection in four main review areas. These including the general condition of the facility, staffing patterns and issues, the activity of the patients and a review of some of the performance improvement

initiatives undertaken by the facility as outlined in their previously submitted plans of correction.

This two-day inspection began with an unannounced visit during the evening of January 15th. This included a tour of F unit, I Units 1&2, and the K unit. Interviews were conducted with staff and patients. Sections of eight clinical records were reviewed. Administrative staff was interviewed the following day with a focus on the facility's progress towards performance initiatives identified in previously submitted Office of the Inspector General reports.

Northern Virginia Mental Health Institute is the state-operated psychiatric hospital that serves the Northern Virginia metropolitan area. With an operating capacity of 137, the facility serves adult residents of the counties of Arlington, Fairfax and Prince William and the cities of Alexandria, Fairfax and Falls Church.

GENERAL CONDITION OF THE FACILITY

Finding 1.2: The facility was well maintained, clean and comfortable.

Background: Northern Virginia Mental Health Institute was designed and built in the 1960's with expansion renovation occurring in the early 1990's. It is located adjacent to Fairfax Hospital/Northern Virginia in Falls Church. The facility has been well maintained. Recent program changes have resulted in a different utilization of several areas. These changes have allowed for increased office space as well as an active treatment or treatment mall area. Both staff and patients interviewed stated that the changes have served to enhance the effectiveness of the services provided without compromising "living areas". Tours of several units were conducted. Each unit was clean and well maintained. Patients interviewed expressed feeling safe and comfortable. Patients were observed having opportunities to meet with visitors in relative privacy. Literature available for patients' use during leisure time was varied and current.

Recommendation: None. Continue to maintain the facility while balancing the needs for program and living spaces.

Finding 1.2: The facility has closed the H Unit.

Background: Discussions with administrative and line staff indicated that there were several reasons for the decision to close the H unit. This unit was opened in March of 1999 for the purpose of providing intensive and specialized treatment for behaviorally challenging and treatment recalcitrant patients. The management team began to discuss

several concerns about H at the time that they started a Performance Improvement (PI) project on patient aggression in February 2000. Concerns included the overall increased level of high-risk behaviors, the likelihood of increased hospital dependency, and a lack of integration between patients on this unit and the broader hospital environment. Once analysis of these problems occurred, the team began to undertake closure of the unit, by redistributing staff and clients onto other units. Staff at all levels report high satisfaction with this decision and its positive effect on patient outcomes and staff morale. One clear benefit of this restructuring has been the redistribution of clinical psychology department resources throughout the entire hospital. This appears to have translated into integration of behavioral treatment interventions onto each of the other units and to have made available specialized behavioral care to all patients throughout the facility who may have these needs. The closure of this unit which resulted in dissemination of behaviorally challenging and aggressive patients throughout the hospital facilitated the facility performance improvement initiative on patient aggression. Ongoing problems with patients aggression have been identified by the office of Inspector General as one of three overarching problems of significance within our facility system. This would be a good project to share with other facility managers.

Recommendation: **None.**

STAFFING ISSUES

Finding 2.1: The facility has maintained good levels of staffing.

Background: Staffing patterns on the evening of the inspection, a state holiday, were as follows:

F unit: 25 patients, 3 RN's, and 4 HSCW's.

I1 unit: 26 patients, 3 RN's, and 3 HSCW's.

I2 unit: 31 patients, 4 RN's, and 3 HSCW's.

K unit: 44 patients, 3 RN's, and 6 HSCW's.

The team's observations were that these staffing levels were appropriate and therapeutic for providing quality care to the patients. It appeared as though there was positive interaction between staff and patients.

Recommendation: None.

Finding 2.2: Recent change of Primary Care Physician coverage consisting of a contract between NVMHI and the INOVA group, has resulted in increased integration and coordination of medical services in overall patient care.

Background: In October 2000, the facility contracted with an INOVA medical group to provide 24-hour on-site medical treatment. The group consists of 4 physicians and a nurse practitioner, affiliated with the neighboring hospital. The Primary Care Physician, along with the nurse practitioner, runs daily clinic for non-emergency medical issues. Staff commented favorably with this arrangement and indicated that this has resulted in decreased emergency room visits, improved communication, and an overall sense of an integration of medical care into mental health treatment.

Recommendation: None.

Finding 2.3: Improvements in staff morale was evident.

Background: Throughout the inspection, it was evident that there was substantial improvement in staff morale and satisfaction. Not only did staff report these changes but also the inspection team observed that there was a positive relaxed but professional atmosphere throughout the hospital. Staff spoke of feeling supported and functioning as a member of the team. Evening staff spoke of increased opportunities to participate in patient treatment planning as well as hospital performance improvement initiatives. Stability at the higher management levels appears to have had a positive systemic effect at this facility. Staff interviews demonstrated that there has been less turnover among employees at every level in the organization.

Recommendation: Continue to foster a supportive environment that enables commitment to both quality patient care and staff stability.

Finding 2.4: Response time of primary care physician to staff page was within three minutes.

Background: The policy of this facility dictates that the response time is to occur within fifteen minutes of contact by nursing. All unit staff related that physician response to psychiatric and medical pages is consistently within these expectations.

Recommendation: None. This is an excellent response time.

Finding 2.5: The role of the facility in the discharge process has been clarified such that hospital staff are responsible for performing the discharge needs assessment and CSB staff are responsible for securing the resources.

Background: Review of patient records and interviews with staff demonstrate good linkage between hospital and community services board representatives. There appears to be a solid working relationship and community input is well-integrated into patient treatment and discharge planning. However, there is a general consensus that too few community resources are available for appropriate placement of all patients, particularly in the area of housing options. In the past this has resulted in discharge delays for some patients who are otherwise ready for release. This has often resulted in frustration among patients and staff invested in seeing patients make smooth, effective transitions back into community living. The facility is therefore making an effort to frame the discharge plans in terms of a clinical needs assessment for a specific patient, leaving the responsibility for securing appropriate resources to the community services board staff. Roles in the discharge planning process have been sharpened and clarified through the use of an external consultant, Dr. Geller.

Recommendation: Continue to use this paradigm for discharge planning and to maintain positive collaborative relationships with CSB staff.

Recommendation: Encourage exchange of information regarding these efforts in sharpening up the discharge planning process across the state.

Finding 2.6: Processes for daily documentation of patient progress were inconsistent.

Background: Random selection of patient charts for review occurred on each of the units. While the quality of documentation generally appeared to be good and the layout of charts is logical, the process for daily monitoring of patient progress was unclear and inconsistent. The nursing progress notes demonstrated, in some cases, gaps of several days, which seemed to correspond with the holiday period. When the team asked staff about this, they were told that policies and procedures for progress noting require that entries be made in the progress note section only as needed, and that daily monitoring of patient status is reflected in the nursing flow sheets. However, when records were re-checked the following day in several charts, nursing flow sheets could not be located.

Recommendation: Review standard operating procedures for daily nursing documentation and promote uniform application of these practices.

ACTIVITY OF PATIENTS

Finding 3.1: Scheduled evening activities were available for patients during this state holiday.

Background: There was a range of leisure time activities available for patients that seemed individualized. Some patients were engaged in a volleyball game in the gym, one group was participating in a current events activity while others were provided with opportunities and materials for personal projects. Patients were observed interacting with each other in small groups.

Recommendation: None. Continue to provide an array of leisure time activities based on patient interest and preferences.

FOLLOW-UP SUMMARY

One aspect of this inspection was to review the facility's efforts in addressing recommendations from previous OIG visits. It appears as if the staff at NVMHI gave genuine consideration to the recommendations and integrated many of these into their ongoing quality improvement processes.

Indeed it seems that this facility has had maturation of integral organizational components. There was a clear and noticeable sense among all levels of staff of a shared vision and goal of striving to provide quality care. Direct care staff related that the facility administration had been willing to take action regarding their concerns and incorporated many of their ideas into policy and procedures. This was most evident in the performance improvement initiative on patient aggression, which exemplified the overall progress of the facility towards achieving improved patient care through more effective administration of clinical resources. While seclusion and restraint use continues to reduce, administration verbalized that they support its utilization, when appropriate *within a continuum of clinical behavior management techniques*. Given that the reorganization of clinical units seems to have improved patient care and flow; reduced patient aggression has been a goal and outcome of an ongoing Performance Improvement initiative; there is better distribution of a range of clinical services throughout the facility; and increased staff satisfaction is both reported and observed, there is an overall impression of a genuine commitment to a management model of quality assurance at NVMHI.